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To assure equitable coverage and treatment of emergency services under health plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 11, 1995

Mr. CARDIN (for himself, Mrs. ROUKEMA, Mr. MCDERMOTT, Mr. TOWNS, Mr. PALLONE, Ms. RIVERS, Mr. NADLER, Mr. WISE, Mr. LEWIS of Georgia, Mr. FAZIO of California, Mr. MORAN, Mr. BEILENSON, and Mr. JOHNSON of South Dakota) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To assure equitable coverage and treatment of emergency services under health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Access to Emergency Medical Services Act of 1995''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—The Congress finds the following:

(1) Federal medicare law requires emergency physicians and other providers to evaluate, treat, and stabilize any individual seeking treatment in a hospital emergency department.

(2) This law specifically prohibits emergency physicians from delaying any treatment needed to evaluate or stabilize an individual in order to determine the health insurance status of the individual.

(3) Many health plans routinely deny payment for these Federally-required emergency services furnished to their enrollees, basing such denials on—

(A) failure to obtain prior approval of such services from the plan, or

(B) an after-the-fact determination that the medical condition identified through the Federally-required evaluation was not an emergency medical condition.

(4) These denials by health plans impose significant financial burdens on—

(A) their enrollees who, based on symptoms that reasonably suggest a medical emergency, prudently seek care in a hospital emergency department, and

(B) emergency physicians, the hospital emergency departments, and others involved in furnishing emergency services to the enrollees.

(5) These burdens discourage enrollees from seeking emergency care in cases where it is appropriate and, ultimately, threaten the financial livelihood of hospital emergency departments in providing emergency services to the entire population, including beneficiaries of the medicare and medicaid programs and of other Federal health care programs.

(6) Health plans have engaged in practices that discourage the appropriate use of the 911 emergency telephone number and may adversely impact on the health of enrollees.

(b) PURPOSES.—The purposes of this Act are—

(1) to require health plans to cover and pay for their fair share for emergency services that hospital emergency departments are required to provide;

(2) to protect health plan enrollees by establishing a uniform definition of emergency medical condition that is based on the average knowledge of a prudent layperson;

(3) to prohibit health plans from requiring prior approval for Federally-required emergency services; and

(4) to assure that health plans promote the appropriate use of the 911 emergency telephone number.

SEC. 3. ASSURING EQUITABLE HEALTH PLAN COVERAGE WITH RESPECT TO EMERGENCY SERVICES.

(a) PROHIBITION OF CONTRACTUAL LIMITATIONS ON COVERAGE OF EMERGENCY SERVICES.—A health plan that provides any coverage with respect to emergency services shall cover emergency services furnished to an enrollee of the plan—

(1) without regard to whether or not the provider furnishing the emergency services has a contractual or other arrangement with the plan for the provision of such services to such enrollees, and

(2) without regard to prior authorization.

(b) PROHIBITION OF DISCRIMINATORY PAYMENT OR COST-SHARING.—

(1) IN GENERAL.—A health plan that provides any coverage with respect to emergency services—

(A) shall determine and make prompt payment in a reasonable and appropriate amount for such services (including services required to be provided under section 1867 of the Social Security Act), and

(B) subject to paragraph (2), may not impose cost-sharing for services furnished in a hospital emergency department that is calculated in a manner (such as the use of a different percentage) that imposes greater cost sharing with respect to such services compared to comparable services furnished in other settings.

(2) IMPOSITION OF REASONABLE COPAYMENT PERMITTED.—A health plan may impose a reasonable copayment (as determined in accordance with standards established by the Secretary) in lieu of coinsurance to deter inappropriate use of services of hospital emergency departments.

(c) ASSURING TIMELINESS OF PRIOR AUTHORIZATION DETERMINATION FOR NEEDED CARE IDENTIFIED IN INITIAL EVALUATION.—

(1) IN GENERAL.—

(A) ACCESS TO PROCESS.—If an enrollee of a health plan receives emergency services from an emergency department pursuant to a screening evaluation conducted by a treating physician or other emergency department personnel and pursuant to the evaluation such physician or personnel identifies items and services (other than emergency services) promptly needed by the enrollee, the health plan shall provide access 24 hours a day, 7 days a week, to such persons as may be authorized to make any prior authorization determinations respecting coverage of such promptly needed items and services.

(B) DEEMED APPROVAL.—A health plan is deemed to have approved a request for a prior authorization for such promptly needed items and services if such physician or other personnel—

(i) has attempted to contact such a person for authorization—

(I) to provide an appropriate referral for the items and services, or

(II) to provide the items and services to the enrollee,

and access to the person has not been provided (as required under subparagraph (A)), or

(ii) has requested such authorization from such a person and the person has not denied the authorization within 30 minutes after the time the request is made.

(2) REFERRAL BY PHYSICIAN TO HOSPITAL EMERGENCY DEPARTMENT DEEMED PRIOR AUTHORIZATION.—If a physician (or, in the case of a managed care plan, a participating physician or other person authorized to make prior authorization determinations for the plan) refers an enrollee to a hospital emergency department for evaluation or treatment, a request for prior authorization of the items and services reasonably furnished the enrollee pursuant to such referral shall be deemed to have been made and approved.

(3) EFFECT OF APPROVAL.—

(A) IN GENERAL.—Approval of a request for a prior authorization determination (including a deemed approval under paragraph (1) or (2)) shall be treated as approval of any health care items and services required to treat the medical condition identified pursuant to a

screening evaluation referred to in paragraph (1)(A).

(B) PAYMENT.—A health plan may not subsequently deny or reduce payment for an item or service furnished pursuant to such an approval unless the approval was based on information about the medical condition of an enrollee that was fraudulent.

(d) ENCOURAGING APPROPRIATE USE OF 911 EMERGENCY TELEPHONE NUMBER.—A health plan—

(1) shall include, in any educational materials the plan makes available to its enrollees on the procedures for obtaining emergency services—

(A) a statement that it is appropriate for an enrollee to use the 911 emergency telephone number for an emergency medical condition (as defined in section 8(3)), and

(B) an explanation of what is an emergency medical condition;

(2) shall not discourage appropriate use of the 911 emergency telephone number by enrollees with emergency medical conditions; and

(3) shall not deny coverage or payment for an item or service solely on the basis that an enrollee

uses the 911 emergency telephone number to summon treatment for an emergency medical condition.

SEC. 4. REQUIREMENTS FOR MEDICARE AND MEDICAID MANAGED CARE.

(a) MEDICARE.—Subparagraph (B) of section 1876(c)(4) of the Social Security Act (42 U.S.C. 1395mm(c)(4)) is amended to read as follows:

''(B) meets the requirements of section 3 of the Access to Emergency Medical Care Act of 1995 with respect to enrollees of the plan who are enrolled under this section.''.

(b) MEDICAID.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908 the following new section:

''ACCESS TO EMERGENCY SERVICES FOR INDIVIDUALS ENROLLED IN MANAGED CARE PLAN

''SEC. 1909. (a) IN GENERAL.—A state plan may not be approved under this title unless the plan requires each managed care plan providing (or arranging for the provision of) health care items and services to individuals who are eligible for medical assistance and enrolled with the managed care plan to comply with the requirements of section 3 of the Access to Emergency Medical Care Act of 1995 with respect to such individuals.

''(b) WAIVERS PROHIBITED.—The requirement of subsection (a) may not be waived under section 1115 or section 1915(b).

''(c) MANAGED CARE PLAN.—For purposes of this section, the term 'managed care plan' means a health plan that provides or arranges for the provision health care items and services to enrollees primarily through participating physicians and providers.''.

SEC. 5. EFFECT ON STATE LAW.

(a) PREEMPTION.—Nothing in this Act shall be construed as preempting or otherwise superseding any provision of State law unless such provision directly conflicts with this Act.

(b) CONSUMER PROTECTIONS.—A provision of State law shall not be considered to conflict directly with this Act if the provision provides the enrollees of health plans with protections that exceed the protections of this Act.

SEC. 6. ENFORCEMENT.

(a) CIVIL MONEY PENALTIES.—A health plan that violates a requirement of section 3 shall be subject to a civil money penalty of not more than the greatest of—

(1) $10,000 for each such violation;

(2) in the case of a violation of section 3, 3 times the amount that the health plan would have

paid for items and services if the plan had not violated such section; or

(3) in the case of a pattern of repeated and substantial violations, $1,000,000.

(b) PROCEDURES.—

(1) IN GENERAL.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this section in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) of such Act.

(2) CORRECTIVE ACTION.—In determining the amount or scope of any civil money penalty under this section, the Secretary shall take into account whether a health plan has taken corrective action, such as—

(A) payment for items and services for which coverage or payment has been denied in violation of a requirement of section 3, and

(B) establishment of policies and procedures to prevent the same type of violation from occurring in the future.

(c) INDEMNIFICATION.—The Secretary may, out of any civil money penalty collected pursuant to this section, make a payment to an enrollee or provider (as appro-

priate) in an amount equal to the amount a health plan would have paid for an item or service (if any) if the plan had not denied coverage or payment for such item or service in violation of section 3.

(d) VIOLATIONS.—For purposes of subsection (a), the Secretary shall treat at least the following acts or omissions as violations of section 3:

(1) COVERAGE OF EMERGENCY SERVICES.—Failure to cover emergency services in violation of section 3(a).

(2) FAILURE TO PROVIDE FOR PAYMENT.—Failure to provide for payment for emergency services in violation of section 3(b)(1)(A).

(3) IMPROPER COST SHARING.—Imposition of cost sharing in violation of section 3(b)(1)(B).

(4) ACCESS TO PRIOR AUTHORIZATION.—Failure to provide access to prior authorization determinations in violation of section 3(c)(1)(A).

(4) DEEMED APPROVAL.—Failure to pay for services that are deemed to be approved under section 3(c).

(5) EDUCATIONAL MATERIALS.—Failure to include educational materials as required by section 3(d)(1).

(6) USE OF 911.—Discouraging the appropriate use of the 911 emergency telephone number or denial of payment in violation of paragraph (2) or (3) of section 3(d).

SEC. 7. REGULATIONS.

The Secretary shall issue such rules and regulations as may be necessary to carry out the provisions of this Act.

SEC. 8. DEFINITIONS.

For purposes of this Act:

(1) COST-SHARING.—The term ''cost-sharing'' means any deductible, coinsurance amount, copayment, or other out-of-pocket payment that an enrollee is responsible for paying with respect to a health care item or service covered under a health plan.

(2) EMERGENCY DEPARTMENT.—The term ''emergency department'' includes, with respect to a hospital, a trauma center in the hospital if the center—

(A) is designated under section 1213 of the Public Health Service Act, or

(B) is in a State that has not made such designations and is determined by the Secretary

to meet the standards under such section for such designation.

(3) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) placing the person's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4) EMERGENCY SERVICES.—The term ''emergency services'' means—

(A) health care items and services furnished in the emergency department of a hospital, and

(B) ancillary services routinely available to such department,

to the extent they are required to evaluate and treat an emergency medical condition (as defined in paragraph (3)) until the condition is stabilized.

(5) ENROLLEE.—The term ''enrollee'' means, with respect to a health plan, an individual enrolled with the health plan.

(6) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' refers to any plan or arrangement (other than a plan or arrangement described in subparagraph (B)) that provides, or pays the cost of, health benefits, whether through insurance, reimbursement, or otherwise.

(B) EXCEPTION.— A plan or arrangement is described in this subparagraph if it is:

(i) Coverage only for accidental death or dismemberment.

(ii) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

(iii) A Medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act).

(iv) Coverage issued as a supplement to liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A long-term care policy.

(ix) A Federally-funded health care program (except when such program contracts with a health plan to provide items and services to individuals eligible for benefits under the program).

(7) MANAGED CARE PLAN.—The term ''managed care plan'' means a health plan that provides or arranges for the provision of health care items and services to enrollees primarily through participating physicians and providers.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a physician or provider, a physician or provider that furnishes health care items and services to enrollees of managed care plan under an agreement with the plan.

(9) PRIOR AUTHORIZATION DETERMINATION.—The term ''prior authorization determination'' means, with respect to health care items and services for which coverage may be provided under a health plan, a determination, before the provision of the items and services and as a condition of coverage of the items and services under the plan, that coverage will be provided for the items and services under the plan.

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(11) STABILIZED.—The term ''stabilized'' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred in compliance with the requirements of section 1867 of the Social Security Act.

(12) 911 EMERGENCY TELEPHONE NUMBER.—The term ''911 emergency telephone number'' includes, in the case of a geographic area where 911 is not in use for emergencies, such other telephone number as is in use for emergencies.

SEC. 9. EFFECTIVE DATES.

(a) IN GENERAL.—This Act and the amendments made by this Act shall become effective on the earlier of—

(1) 30 days after the date the Secretary issues regulations pursuant to subsection (c), or

(2) 210 days after the date of the enactment of this Act (without regard to whether such regulations have been issued by such date).

(b) APPLICATION.—The provisions of section 3 (other than paragraphs (1) and (2) of subsection (d)) shall apply to items and services furnished on or after the effective date described in subsection (a).

(c) DEADLINE FOR REGULATIONS.—The Secretary shall issue regulations to implement this Act and the amendments made by this Act not later than 6 months after the date of the enactment of this Act. Such regulations may take effect on a final basis at the time of publication, subject to revision based on subsequent public comment.

SEC. 10. REPORT ON APPLICATION TO PLANS INCLUDING MEDICAL SAVINGS ACCOUNTS.

(a) STUDY.—The Secretary shall provide for a study of the application of this Act in the case of health plans composed of a high-deductible, catastrophic health insurance policy with a medical savings account. In particular, the study shall evaluate the feasibility and desirability of

requiring the application of amounts in such an account toward costs in providing emergency services and in providing promptly needed items and services identified in connection with the provision of emergency services.

(b) REPORT.—The Secretary shall submit to Congress a report on such study not later than 18 months after the date of the enactment of this Act.

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